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APPLICATION NO.	FILING DATE	FIRST NAMED INVENTOR	ATTORNEY DOCKET NO.	CONFIRMATION NO.
09/558,519	04/26/2000	Peter V. Boesen M.D.	P04179US0	9687
22885 7590 05/12/2009 MCKEE, VOORHEES & SEASE, P.L.C. 801 GRAND AVENUE SUITE 3200 DES MOINES, IA 50309-2721			EXAMINER PASS, NATALIE	
			ART UNIT 3686	PAPER NUMBER
			MAIL DATE 05/12/2009	DELIVERY MODE PAPER

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**BEFORE THE BOARD OF PATENT APPEALS  
AND INTERFERENCES**

Application Number: 09/558,519  
Filing Date: April 26, 2000  
Appellant(s): BOESEN M.D., PETER V.

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Jeffrey D. Harty  
For Appellant

**EXAMINER'S ANSWER**

This is in response to the appeal brief filed 17 February 2009 appealing from the Office action mailed 17 September 2008.

**(1) Real Party in Interest**

A statement identifying by name the real party in interest is contained in the brief.

**(2) Related Appeals and Interferences**

The examiner is not aware of any related appeals, interferences, or judicial proceedings which will directly affect or be directly affected by or have a bearing on the Board's decision in the pending appeal.

**(3) Status of Claims**

The statement of the status of claims contained in the brief is correct.

**(4) Status of Amendments After Final**

The appellant's statement of the status of amendments after final rejection contained in the brief is correct.

**(5) Summary of Claimed Subject Matter**

The summary of claimed subject matter contained in the brief is correct.

**(6) Grounds of Rejection to be Reviewed on Appeal**

The appellant's statement of the grounds of rejection to be reviewed on appeal is substantially correct. The changes are as follows: Appellant's statement of the grounds of rejection to be reviewed on appeal does not include the following:

Claims 84-89, 92-94, 98-100, 102-103, 105, 108, 110 are rejected under 35 U.S.C. 103(a).

**(7) Claims Appendix**

The copy of the appealed claims contained in the Appendix to the brief is correct.

**(8) Evidence Relied Upon**

1. 6, 393, 404 B2	Waters et al.	05-2002
2. 5, 325, 293 A	Dorne	06-1994
3. 5, 823, 949 A	Goltra	10-1998
4. 5, 772, 585 A	Lavin	06-1998

**(9) Grounds of Rejection**

The following ground(s) of rejection are applicable to the appealed claims:

Claims 84-89, 92-94, 98-100, 102-103, 105, 108, 110 are rejected under 35 U.S.C. 103(a).

These rejections are set forth in prior Office Action, Paper No 20080829 and reproduced hereinbelow. The rejections that appear below substantially repeat the rejections made in the previous Office Action (Paper Number 20080829). The text of those sections of Title 35 U.S. Code relied upon in the Examiner's Answer is set forth in the previous Office action, Paper Number 20080829.

1. Claims 84, 88-89, 94, 98-100, 102-103, 110 are rejected under 35 U.S.C. 103(a) as being unpatentable over Waters et al., U.S. Patent Number 6, 393, 404 in view of Dorne, U.S. Patent Number 5, 325, 293 and Goltra, U.S. Patent Number 5, 823, 949.

(A) As per claim 84, Waters discloses a method for providing medical coding, comprising:

receiving a selection of a patient procedure code on a first computer (Waters; Figure 3, column 3, lines 52-65), the patient procedure code representing a procedure performed on a patient during a patient encounter (Waters; Abstract, column 2, lines 47-48);

receiving a selection of a plurality of diagnosis codes on the first computer (Waters; Figure 2, column 3, lines 30-51), each of the plurality of diagnosis codes representing a diagnosis applicable to the procedure performed as “the medical professional ... [...] ... diagnoses the patient’s condition” (reads on “during the patient encounter”) (Waters; Figure 2, column 2, lines 23-26, column 3, lines 8-51).

Although Waters teaches linking the patient procedure code to the diagnosis code (Waters; column 3, lines 53-65), Waters fails to explicitly disclose

linking the selection of the patient procedure code to the selection of the plurality of diagnosis codes on the first computer.

However, the above features are well-known in the art, as evidenced by Dorne.

In particular, Dorne teaches

linking the selection of the patient procedure code to the selection of the plurality of diagnosis codes on the first computer (Dorne; column 16, lines 9-22).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the system of Waters to include the claimed limitations, as taught by Dorne, with the motivations of providing “a method and system for rapidly and simply correlating” diagnosis and procedure codes “with medical procedures performed during a patient examination which does not require a thorough understanding of the nomenclature used by the ... [...] ... coding system,” reducing time spent coding by busy physicians, and enabling more efficient payments from Medicare and private insurance companies for physician’s services (Dorne; column 3, lines 10-28).

Although Waters teaches providing a user interface (Waters; Figure 2, Figure 3) that allows the user to configure the system to select or rank selected codes (Waters; Figure 3, column 3, lines 30-37), and although Waters teaches documenting the patient encounter (Waters; Abstract, column 2, lines 47-48), Waters fails to explicitly disclose

providing a user interface adapted for ranking the plurality of diagnosis codes linked with the patient procedure code in a user defined rank order after receiving the selection of the plurality of diagnosis codes; and

documenting the patient encounter by storing the rank ordering of the selection of the plurality of diagnosis codes linked to the selection of the patient procedure code of the procedure performed to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis supporting the procedure performed.

However, the above features are well-known in the art, as evidenced by Goltra.

In particular, Goltra teaches

providing a user interface adapted for ranking the plurality of diagnosis codes linked with the patient “medical finding” (reads on “procedure”) code in a user defined rank order after receiving the selection of the plurality of diagnosis codes (Goltra; column 2, lines 25-58, column 3, lines 39-41, column 4, line 58 to column 5, line 31, column 6, lines 6-10); and

documenting the patient encounter by storing the rank ordering of the selection of the plurality of diagnosis codes linked to the selection of the patient “medical finding” (reads on “procedure”) code of the procedure performed (Goltra; column 6, lines 1-8) to thereby provide a record of the “medical finding” (reads on “procedure performed”) (Goltra; column 3, lines 22-28, 39-50), a record of each diagnosis supporting the “medical finding” (reads on “procedure performed”) (Goltra; column 4, lines 57-60), and a user defined ranking of each diagnosis supporting the procedure performed (Goltra; column 2, lines 52-55, column 4, line 57 to column 5, line 7, column 6, lines 1-8).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the combined teachings of Waters and Dorne to include the claimed limitations, as taught by Goltra, with the motivations of providing “a good archival record of what has been done for a particular patient,” thereby enabling “tracking ... [of] ... problem[s] for quality control, legal or other reasons,” and for “research[ing] the relative effectiveness of various interventions,” and additionally for enabling “healthcare professionals who must adequately document the examination and treatment of patients” to “provide proper

documentation,” e.g. for insurers, as to treatments or procedures prescribed during patient encounters so that insurance companies will pay the bills (Goltra; column 2, lines 1-22).

(B) As per claims 88-89, 94 Waters, Dorne and Goltra teach a method as analyzed and discussed in claim 84 above further comprising

associating the patient procedure code and the linked plurality of diagnosis codes with patient data including patient identifying information (Waters; column 4, lines 2-8);

sending patient data, including patient identifying information to the first computer from a second computer prior to the steps of receiving a selection of a patient procedure code and receiving a selection of the plurality of diagnosis codes (Waters; column 4, lines 2-8); and

generating a patient bill based on the selection of the patient procedure code and the selection of the plurality of diagnosis codes (Dorne; column 3, lines 18-39, column 19, lines 9-19).

The motivations for combining the respective teachings of Waters, Dorne and Goltra are as given in the rejection of claim 84 above, and incorporated herein.

(C) As per claim 98, Waters, Dorne and Goltra teach a method for providing code-driven medical reporting for billing purposes, comprising:

receiving a selection of a patient procedure code on a first computer (Waters; Figure 3, column 3, lines 52-65), the patient procedure code representing a patient procedure performed on a patient during a patient encounter (Waters; Abstract, column 2, lines 47-48);



receiving a selection of a plurality of diagnosis codes on the first computer (Waters; Figure 2, column 3, lines 30-51), each of the plurality of diagnosis codes representing a diagnosis of the patient as “the medical professional ... [...] ... diagnoses the patient’s condition” (reads on “during the patient encounter”) (Waters; Figure 2, column 2, lines 23-26, column 3, lines 8-11, 44-51);

receiving a change in ordering of diagnosis codes from a user (Goltra; column 2, lines 25-27, column 4, line 58 to column 5, line 31, column 6, lines 6-10);

linking the selection of the patient procedure code to the selection of the plurality of diagnosis codes on the first computer (Dorne; column 16, lines 9-22); and

charting (reads on “documenting”) (Goltra; column 6, lines 1-8) the linking of the selection of the patient procedure code and the selection of the plurality of diagnosis codes to provide for “keeping track of the ICD-9 diagnostic codes most likely associated with the procedures selected by the user” (reads on “maintaining a user defined rank ordered relationship between the patient procedure code and the plurality of diagnosis codes based on the patient encounter”) to thereby provide a detailed record of the patient encounter (Dorne; Abstract, column 8, lines 49-52, column 9, lines 6-11, column 12, lines 46-50, column 16, lines 9-12, 20-21).

The motivations for combining the respective teachings of Waters, Dorne and Goltra are as given in the rejection of claim 84 above, and incorporated herein.

(D) As per claims 99-100, 102-103, 110, Waters, Dorne and Goltra teach a method as analyzed and discussed in claims 84 and 98 above

wherein each of the plurality of diagnosis codes is an ICD code (Dorne; column 16, lines 9-19);

wherein the patient procedure code is a CPT code (Dorne; column 16, lines 20-21);

wherein a modifier is associated with the patient procedure code (Dorne; Figure 7, column 8, line 63 to column 9, line 2, column 10, lines 10-13); and

wherein a unit value or RVU is assigned to the patient procedure code (Dorne; Figure 3G, column 1, lines 21-26, column 6, line 66 to column 7, line 4).

The motivations for combining the respective teachings of Waters, Dorne and Goltra are as given in the rejection of claim 84 above, and incorporated herein.

2. Claims 85-87 are rejected under 35 U.S.C. 103(a) as being unpatentable over Waters et al., U.S. Patent Number 6, 393, 404, Dorne, U.S. Patent Number 5, 325, 293 and Goltra, U.S. Patent Number 5, 823, 949, as applied to claim 84 above, and further in view of Lavin et al, Pat. No. 5,772,585.

(A) As per claim 85, Waters, Dorne and Goltra teach a method as analyzed and discussed in claim 84 above.

Waters, Dorne and Goltra fail to explicitly disclose electronically sending patient data including the patient procedure code and the plurality of diagnosis codes from the first computer to a second computer.

However, the above features are well-known in the art, as evidenced by Lavin.

In particular, Lavin teaches

electronically sending patient data including the patient procedure code and the plurality of diagnosis codes from the first computer to a second computer (Lavin; column 9, lines 34-56, column 13, lines 29-59).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the collective teachings of Waters, Dorne and Goltra to include the claimed limitations, as taught by Lavin, with the motivations of providing a method for concurrently recording examination and diagnoses notes in a database during patient examination and enabling data entry and access to multiple items of information, previously recorded on separate paper and electronic media, at a common user interface and database structure simultaneously by more than one user, thus eliminating redundant data entry and centralization of patient information (Lavin; column 2, line 65 to column 3, line 11).

(B) As per claims 86-87, Waters, Dorne, Goltra and Lavin teach a method as analyzed and discussed in claims 84 and 85 above

further comprising displaying the patient procedure code and the linked plurality of diagnosis codes on a display of the first computer prior to the step of electronically sending (Waters; Figure 2, Figure 3, column 3, lines 53-64); and

generating a patient bill at the second computer, the patient bill associated with the patient data (Lavin; column 9, lines 38-40 and column 13, lines 56-59).

The motivations for combining the respective teachings of Waters, Dorne, Goltra and Lavin are as given in the rejections of claims 84 and 85 above, and incorporated herein.

3. Claims 92-93, 105, 108, are rejected under 35 U.S.C. 103(a) as being unpatentable over Waters et al., U.S. Patent Number 6, 393, 404 in view of Goltra, U.S. Patent Number 5, 823, 949.

(A) As per claim 92, Waters teaches a method for providing code-driven medical reporting comprising:

receiving a selection of a plurality of diagnosis codes on a first computer (Waters; Figure 2, column 3, lines 30-51), each of the plurality of diagnosis codes representing one diagnosis applicable to a patient procedure code representing a procedure performed as “the medical professional ... [...] ... diagnoses the patient’s condition” (reads on “on a patient during a patient encounter”) (Waters; Figure 2, Figure 3, column 2, lines 23-26, 47-48, column 3, lines 44-51); and

receiving a selection of the patient procedure code on the first computer (Waters; Figure 3, column 3, lines 52-65), the patient procedure code representing the patient procedure performed on the patient during the patient encounter (Waters; Abstract, column 2, lines 47-48).

Although Waters teaches linking the patient procedure code to the diagnosis code (Waters; column 3, lines 53-65), Waters fails to explicitly disclose

receiving a change in ordering of diagnosis codes within the plurality of diagnosis codes within a user defined rank order list; and

linking the plurality of diagnosis codes in a user defined rank order to the patient procedure code such that a defined relationship between the patient procedure code and the plurality of diagnosis codes is maintained to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis supporting the procedure performed to provide a record of the patient encounter.

However, the above features are well-known in the art, as evidenced by Goltra.

In particular, Goltra teaches

receiving a change in ordering of diagnosis codes within the plurality of diagnosis codes within a user defined rank order list (Goltra; column 2, lines 25-27, column 4, line 58 to column 5, line 31, column 6, lines 6-10); and

linking the plurality of diagnosis codes in a user defined rank order to the patient procedure code such that a defined relationship between the patient procedure code and the plurality of diagnosis codes is maintained to thereby provide a record of the “medical finding” (reads on “procedure performed”) (Goltra; column 3, lines 22-28, 39-50), a record of each diagnosis supporting the “medical finding” (reads on “procedure performed”) (Goltra; column 4, lines 57-60), and a user defined ranking of each diagnosis supporting the procedure performed (Goltra; column 2, lines 52-55, column 4, line 57 to column 5, line 7, column 6, lines 1-8) to provide a record of the patient encounter (Goltra; column 2, lines 25-27, column 4, line 58 to column 5, line 31, column 6, lines 1-10).

It would have been obvious to one of ordinary skill in the art at the time the invention was made to modify the system of Waters to include the claimed limitations, as taught by Goltra, with the motivations of providing “a good archival record of what has been done for a particular patient,” thereby enabling “tracking ... [of] ... problem[s] for quality control, legal or other reasons,” and for “research[ing] the relative effectiveness of various interventions,” and additionally for enabling “healthcare professionals who must adequately document the examination and treatment of patients” to “provide proper documentation,” e.g. for insurers, as to treatments or procedures prescribed during patient encounters so that insurance companies will pay the bills (Goltra; column 2, lines 1-22).

(B) As per claim 93, Waters and Goltra teach a method as analyzed and discussed in claim 92 above

further comprising generating a bill based on the patient procedure code and the plurality of diagnosis codes (Waters; column 2, lines 23-28, column 3, lines 62-64).

(C) As per claim 105, Waters and Goltra teach a method for providing code-driven medical reporting, comprising:

providing a user interface adapted for operation on a first computer (Waters; Figure 3, Abstract, column 3, lines 40-43);

using the user interface to collect at least one procedure code representing a procedure performed on a patient during a patient encounter (Waters; Figure 3, Abstract, column 2, lines 47-48, column 3, lines 52-65);

for each of the at least one “medical finding” (reads on “procedure”) code, using the user interface to collect a plurality of diagnosis codes, each of the plurality of diagnosis codes representing a diagnosis of the patient during the patient encounter to thereby establish a user defined link (Goltra; column 2, lines 25-27, column 5, lines 2-6) between each of the plurality of “medical findings” (reads on “procedure”) codes and the plurality of diagnosis codes (Goltra; column 4, line 58 to column 5, line 31, column 6, lines 6-10);

using the user interface to reorder the plurality of diagnosis codes (Goltra; column 2, lines 25-27, column 4, line 58 to column 5, line 31, column 6, lines 6-10); and

documenting the patient encounter by storing each of the at least one procedure codes and storing each of the at least one diagnosis codes linked to each of the at least one procedure codes to provide a record of each set of diagnosis codes collected for each procedure code (Goltra; column 6, lines 1-8) and a rank order of each set of diagnosis codes (Goltra; column 2, lines 25-27, column 4, line 58 to column 5, line 31, column 6, lines 6-10).

The motivations for combining the respective teachings of Waters and Goltra are as given in the rejection of claim 84 above, and incorporated herein.

(D) As per claim 108, Waters and Goltra teach a method as analyzed and discussed in claim 105 above

wherein the procedure code is a CPT code (Waters; column 1, lines 52-54).

#### **(10) Response to Argument**

In the Appeal Brief filed 17 February 2009, Appellant makes the following argument:

### **VIII. Argument**

**A. Claims 84, 88-89, 94, 98-100, 102-103, and 110 are patentably distinguishable from U.S Patent No. 6, 393, 404 to Waters et al. in view of U.S Patent No. 5, 325, 493 to Dorne and U.S Patent No. 5, 823, 949 to Goltra.**

1. Waters et al. is largely deficient.
2. Waters et al. teaches away from the claimed invention because Waters et al. selects codes for usage based on optimized billing and not to better document the patient encounter.
3. The Examiner failed to properly consider the scope and content of the prior art, as the Examiner fails to properly consider Dorne.
4. The Examiner failed to properly consider the scope and content of the prior art, as the Examiner fails to properly consider Goltra.
5. None of the cited prior art references teach "documenting the patient encounter by storing the rank ordering of the selection of the plurality of diagnosis codes linked to the selection of the patient procedure code of the procedure performed to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis supporting the procedure performed."



6. None of the cited prior art alone or in combination teach "receiving a change in ordering of diagnosis codes" or "maintaining a user defined rank ordered relationship between the patient procedure code and the plurality of diagnosis codes based on the patient encounter to thereby provide a detailed record of the patient encounter" as recited in claim 98.
7. Lavin et al. does not remedy the deficiencies of Waters et al. Dorne and Goltra and thus the Examiner should reverse with respect to claims 85-87.

**B. Claims 92-93, 105 and 108 are patentably distinguishable from U. S. Patent No.6,393,404 to Waters et al. in view of U. S. Patent No. 5,823,949 to Goltra.**

1. The Examiner fails to properly consider the scope and content of the prior art and must be reversed with respect to claims 92-93 because neither Waters et al. nor Goltra alone or in combination teach "linking the plurality of diagnosis codes in a user defined rank order to the patient procedure code such that a defined relationship between the patient procedure code and the plurality of diagnosis codes is maintained to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis supporting the procedure performed to provide a record of the patient encounter."
2. The Examiner fails to properly consider the scope and content of the prior art and must be reversed with respect to claims 105 and 108 because neither Water et al.

nor Goltra alone or in combination teach "linking the plurality of diagnosis codes in a user defined rank order to the patient procedure code such that a defined relationship between the patient procedure code and the plurality of diagnosis codes is maintained to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis supporting the procedure performed to provide a record of the patient encounter."

Examiner will address Appellant's arguments in sequence as they appear in the brief.

### **VIII. Argument**

**A. Claims 84, 88-89, 94, 98-100, 102-103, and 110 are patentably distinguishable from U.S Patent No. 6, 393, 404 to Waters et al. in view of U.S Patent No. 5, 325, 493 to Dorne and U.S Patent No. 5, 823, 949 to Goltra.**

**1. Waters et al. is largely deficient.**

At pages 7-8 of the Appeal Brief Appellant analyzes the applied references separately and argues each of the references individually. In response to Appellant's piecemeal arguments analysis of the references, it has been held that one cannot show nonobviousness by attacking references individually where, as here, the rejections are based on combinations of references. See *In re Keller*, 642 F.2d 413, 208 USPQ 871 (CCPA 1981); *In re Merck & Co.*, 800 F.2d 1091, 231 USPQ 375 (Fed Cir. 1986).

As per Appellant's assertions that the limitations of claim 84 are not taught or suggested by the Waters reference, Examiner notes that all of the limitations which Appellant disputes are missing have been fully addressed by the Examiner as being obvious in view of the combined teachings of Waters, Dorne, Goltra and Lavin based on the logic and sound scientific reasoning of one ordinarily skilled in the art at the time of the invention, as detailed in the 35 USC § 103 rejections given in the preceding sections of the present Appeal Brief, and incorporated herein.

In particular, Examiner submits that Waters teaches

“a system and method for optimizing medical diagnosis, procedures and reimbursement claims using a structured search space ... [...] ... The system may include: a master procedure list of alphanumeric codes that represent each of a plurality of medical procedures, wherein the master procedure list includes simple procedures and compound procedures which consist of at least two simple procedures, ... [...] ... a list of ordered procedures listing medical procedures for a specific medical encounter; a search tree of all possible combinations of the simple procedures and the compound procedures in the list of ordered procedures ... [...] ...” (emphasis added) (Waters; column 2, lines 40-54).

Examiner notes that Waters also teaches

“the attending medical professional [of the medical encounter] records the medical diagnosis and ordered medical procedures and then another medical professional enters the information [thus documenting the patient encounter] into a general purpose computer ... [...] ... ” (Waters; column 2, lines 29-32, column 3, line 66 to column 4, line 2);

and

“[t]he diagnosis code represents the diagnosed illness or malady or in some cases just the fact that the patient is having a routine checkup. The procedure code represents the procedure being ordered and is [linked or] associated with the diagnosis code on the basis of medical necessity ... [...] ... ” (emphasis added) (Waters; column 1, lines 24-29);

and Waters teaches

“[t]he present invention is a system and method that takes a given set of ordered medical procedure codes and constructs a search space representing all possible combinations of simple and compound procedures, which is then traversed in a systematic manner using an evaluation method for each node ... [...] ... ” (Waters; column 2, lines 6-11).

Accordingly, Waters has been used as the primary reference in the rejections of Appellant’s claims under 35 U.S.C. 103(a).

However, as discussed above, although Waters teaches linking the patient procedure code to the diagnosis code (Waters; column 3, lines 53-65), Waters fails to explicitly disclose linking the selection of the patient procedure code to the selection of the plurality of diagnosis codes on the first computer, a limitation which Examiner asserts is taught by the Dorne reference.

Examiner notes that Dorne teaches “storing all CPT codes associated with the selected procedures” (Dorne; column 15, lines 60-61);

and

“[t]he interactive program preferably also has the capability of keeping track of the ICD-9 diagnostic codes most likely associated with the procedures selected by the user. Specifically, after sorting the final code system variable, the interactive program proceeds to an activity block 372 and recalls from memory all of the likely ICD-9 codes associated with the procedures that the user has selected. The ICD-9 codes are diagnostic codes

specified by the International Classification of Diseases (9th revision). The interactive program stores these codes to a ICD-9 system variable ... [...] ... After generating and ordering [ranking] the CPT codes associated with the selected procedure ... [...] ...” (emphasis added ) (Dorne; column 16, lines 9-21);

Examiner also notes that Dorne further teaches documenting a patient encounter by storing “all the information required to recall each examination screen of a particular record” (Dorne; column 16, lines 48-50) and “saving the examination record to the hard disk” (Dorne; column 16, line 62). Examiner interprets Dorne’s teachings to teach a form of “linking the selection of the patient procedure code to the selection of the plurality of diagnosis codes on the first computer,” and has provided motivations for combining the teachings of Dorne with the Waters reference in the rejection of claim 84 above.

Moreover, as discussed above, although Waters teaches providing a user interface (Waters; Figure 2, Figure 3) that allows the user to configure the system to select or rank selected codes (Waters; Figure 3, column 3, lines 30-37), and although Waters teaches documenting the patient encounter (Waters; Abstract, column 2, lines 47-48), Waters fails to explicitly disclose providing a user interface adapted for ranking the plurality of diagnosis codes linked with the patient procedure code in a user defined rank order after receiving the selection of the plurality of diagnosis codes; and documenting the patient encounter by storing the rank ordering of the selection of the plurality of diagnosis codes linked to the selection of the patient procedure code of the procedure performed to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis

supporting the procedure performed, limitations which Examiner asserts are taught by the Goltra reference.

Examiner submits that Goltra recognizes that “there is a need for a computer based medical system which enhances the diagnostic, management and documentation capabilities of a healthcare provider, and provides patient charts as well as updated or historical care plans” (Goltra; column 2, lines 34-38), and that Goltra defines an “invention [that] is based upon medical findings. Medical findings are defined as symptoms, history, physical findings, diagnoses, tests, and [procedures] therapy which may be present for a particular patient,” (Goltra; column 3, lines 22-25).

Examiner notes that Goltra also teaches

“[w]hen the intelligent prompting feature is selected, the computerized medical system takes each medical finding entered into the protocol and builds an internal list of possible diagnoses. The list of possible diagnoses is formed by using the point values assigned to each medical finding for each diagnosis stored in the knowledge base file 22. When all of the medical findings have been added together for each diagnosis, the diagnoses are ranked in descending point total. The computerized medical system then selects a predetermined number of diagnoses. For example, the computerized medical system could select the top five diagnoses. It will be understood that while the computerized medical system may be set to a default value, it may be possible for a healthcare professional to change the system [user defined] so as to only use, for example, the top two diagnoses or the top 10 diagnoses, depending on the desires of the healthcare professional” (emphasis added) (Goltra; column 4, line 57 to column 5, line 7).

Examiner interprets Goltra's teachings to teach a form of these limitations, and has provided motivations for combining the teachings of Goltra within the combined teachings of Waters and Dorne in the rejection of claim 84 above.

2. Waters et al. teaches away from the claimed invention because Waters et al. selects codes for usage based on optimized billing and not to better document the patient encounter.

As per Appellant's argument that Waters "teaches away from the claimed methodology," because Waters teaches optimizing billing, Examiner respectfully disagrees. Examiner notes that Waters teaches different embodiments, one of which is optimizing billing. However, Waters also teaches "[t]he present invention relates generally to a system and method to optimize medical diagnosis, procedures and reimbursement claims using a structured search space" (Waters; column 1, lines 6-8) and "[i]n addition, an optimization of the medical procedures prescribed for a particular medical encounter is also needed" (Waters; column 1, lines 62-64).

Furthermore, in Appellant's own Specification (page 1, paragraph 1) is stated:

[t]he present invention relates generally to a billing and records system. More particularly, though not exclusively, the present invention relates to a code-driven computerized system for health care billing that places the responsibility for billing on the health care provider at the point of service."

Accordingly, Examiner asserts that Waters does not teach solely optimizing billing, but optimizing diagnosis and procedures as well, and in addition, teaching optimizing billing is not teaching away from Appellant's invention.

3. The Examiner failed to properly consider the scope and content of the prior art, as the Examiner fails to properly consider Dorne.

At pages 8-9 of the Appeal Brief, Appellant argues that the features of “maintaining a linkage between each procedure code and particular diagnosis codes” are not disclosed or suggested by the Dorne reference. Examiner respectfully disagrees.

Examiner has pointed out particular references contained in the prior art of record within the body of the previous Office Actions, and of this Examiner's Answer, for the convenience of the Appellant. Although the specified citations are representative of the teachings in the art and are applied to the specific limitations within the individual claim, other passages and figures may apply. Appellant, in preparing the response, should consider fully the entire reference as potentially teaching all or part of the claimed invention, as well as the context of the passage as taught by the prior art or disclosed by the Examiner.

As discussed earlier in this Examiner's Answer, Examiner notes that Dorne teaches “storing all CPT codes associated with the selected procedures” (Dorne; column 15, lines 60-61);

And Dorne teaches

“[t]he interactive program preferably also has the capability of keeping track of the



ICD-9 diagnostic codes most likely associated with the procedures selected by the user. Specifically, after sorting the final code system variable, the interactive program proceeds to an activity block 372 and recalls from memory all of the likely ICD-9 codes associated with the procedures that the user has selected. The ICD-9 codes are diagnostic codes specified by the International Classification of Diseases (9th revision). The interactive program stores these codes to a ICD-9 system variable ... [...] ... After generating and ordering [ranking] the CPT codes associated with the selected procedure ... [...] ...” (emphasis added ) (Dorne; column 16, lines 9-21);

Examiner interprets Dorne’s teachings to teach a form of “linking the selection of the patient procedure code to the selection of the plurality of diagnosis codes on the first computer.”

As per Appellant’s argument that Dorne fails to teach “a user defined rank ordered relationship between the patient procedure code and the plurality of diagnosis codes based on the patient encounter,” Examiner respectfully notes that it was the Goltra reference that was applied to teach this limitation.

4. The Examiner failed to properly consider the scope and content of the prior art, as the Examiner fails to properly consider Goltra.

As per Appellant’s argument that Goltra fails to teach “providing a user interface adapted for ranking the plurality of diagnosis codes linked with the patient procedure code in a user defined rank order after receiving the selection of the plurality of diagnosis codes, Examiner respectfully disagrees. Examiner interprets Goltra’s teachings of “the computerized medical

system takes each medical finding entered into the protocol and builds an internal list of possible diagnoses. The list of possible diagnoses is formed by using the point values assigned to each medical finding for each diagnosis stored in the knowledge base file 22. When all of the medical findings have been added together for each diagnosis, the diagnoses are ranked in descending point total. The computerized medical system then selects a predetermined number of diagnoses. For example, the computerized medical system could select the top five diagnoses. It will be understood that while the computerized medical system may be set to a default value, it may be possible for a healthcare professional to change the system [user defined] so as to only use, for example, the top two diagnoses or the top 10 diagnoses, depending on the desires of the healthcare professional” (emphasis added) (Goltra; column 4, line 57 to column 5, line 7) to teach a form of these limitations.

5. None of the cited prior art references teach "documenting the patient encounter by storing the rank ordering of the selection of the plurality of diagnosis codes linked to the selection of the patient procedure code of the procedure performed to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis supporting the procedure performed."

As per Appellant's argument that limitations of claim 84, as listed in this section, are not taught by the applied references, these issues have been discussed earlier in this Examiner's

Answer.

6. None of the cited prior art alone or in combination teach "receiving a change in ordering of diagnosis codes" or "maintaining a user defined rank ordered relationship between the patient procedure code and the plurality of diagnosis codes based on the patient encounter to thereby provide a detailed record of the patient encounter" as recited in claim 98.

As per Appellant's arguments that the applied art fails to teach "receiving a change in ordering of diagnosis codes from a user," as recited in claim 98, Examiner respectfully disagrees. Examiner interprets Goltra's teachings of a system that is "configurable by the healthcare professional" (Goltra; column 2, lines 25-27) and "[w]hen all of the medical findings have been added together for each diagnosis, the diagnoses are ranked in descending point total. The computerized medical system then selects a predetermined number of diagnoses ... [...] ... It will be understood that while the computerized medical system may be set to a default value, it may be possible for a healthcare professional to change the system [user defined]" to teach a form of "receiving a change in ordering of diagnosis codes from a user"

As per Appellant's arguments that the applied art fails to teach "maintaining a user defined rank ordered relationship between the patient procedure code and the plurality of diagnosis codes based on the patient encounter to thereby provide a detailed record of the patient encounter" as recited in claim 98, these issues have been discussed earlier in this Examiner's Answer.

7. Lavin et al. does not remedy the deficiencies of Waters et al. Dorne and Goltra and thus the Examiner should reverse with respect to claims 85-87.

There is no specific argument under this heading; the subject matter is discussed above. Moreover, Examiner respectfully notes that claims 84-87 are not listed in Appellant's list of grounds of rejection to be reviewed on appeal

**B. Claims 92-93, 105 and 108 are patentably distinguishable from U. S. Patent No.6,393,404 to Waters et al. in view of U. S. Patent No. 5,823,949 to Goltra.**

1. The Examiner fails to properly consider the scope and content of the prior art and must be reversed with respect to claims 92-93 because neither Waters et al. nor Goltra alone or in combination teach "linking the plurality of diagnosis codes in a user defined rank order to the patient procedure code such that a defined relationship between the patient procedure code and the plurality of diagnosis codes is maintained to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis supporting the procedure performed to provide a record of the patient encounter."

As per Appellant's argument that limitations of claim 92, as listed in this section, are not taught by the applied references, these issues have been discussed earlier in this Examiner's Answer. Examiner respectfully notes that limitations of claim 93 are not argued in this section.

2. The Examiner fails to properly consider the scope and content of the prior art and must be reversed with respect to claims 105 and 108 because neither Water et al. nor Goltra alone or in combination teach "linking the plurality of diagnosis codes in a user defined rank order to the patient procedure code such that a defined relationship between the patient procedure code and the plurality of diagnosis codes is maintained to thereby provide a record of the procedure performed, a record of each diagnosis supporting the procedure performed, and a user defined ranking of each diagnosis supporting the procedure performed to provide a record of the patient encounter."

As per Appellant's argument that limitations of claims 105 and 108, as listed in this section, are not taught by the applied references, these issues have been discussed earlier in this Examiner's Answer.

In response to Appellant's argument that the Examiner's conclusion of obviousness is based upon improper hindsight reasoning, it must be recognized that any judgment on obviousness is in a sense necessarily a reconstruction based upon hindsight reasoning. But so long as it takes into account only knowledge which was within the level of ordinary skill at the time the claimed invention was made, and does not include knowledge gleaned only from the

Applicant's disclosure, such a reconstruction is proper. See *In re McLaughlin*, 443 F.2d 1392, 170 USPQ 209 (CCPA 1971).

Moreover, Examiner submits that it would have been obvious to one of ordinary skill in the art to include within Waters' code-driven system and method for optimizing medical diagnosis, procedures and claims the feature of linking of the procedure code to the plurality of diagnosis codes, as taught by Dorne, and the user-defined rank ordering of diagnosis codes, as taught by Goltra, since the claimed invention is merely a combination of old elements, and in the combination each element merely would have performed the same function as it did separately, and one of ordinary skill in the art would have recognized that the results of the combination were predictable.

In addition, *KSR* forecloses the argument that a *specific* teaching, suggestion, or motivation is required to support a finding of obviousness. As noted by the court in *KSR*: "[a] person of ordinary skill is also a person of ordinary creativity, not an automaton." 127 S.Ct. at 1742, 82 USPQ2d at 1397 and "Common sense teaches, however, that familiar items may have obvious uses beyond their primary purposes, and in many cases a person of ordinary skill will be able to fit the teachings of multiple patents together like pieces of a puzzle." *KSR Int'l Co. v. Teleflex Inc.*, 127 S.Ct. at 1742, 82 USPQ2d at 1397 (2007).

As such, it is respectfully submitted that Appellant appears to view the applied references separately, without considering the knowledge of average skill in the art, and further fails to appreciate the breadth of the claim language that is presently recited.

#### **(11) Related Proceeding(s) Appendix**

No decision rendered by a court or the Board is identified by the examiner in the Related Appeals and Interferences section of this examiner's answer.

#### ***Conclusion***

Appellant's arguments at pages 7-14 of the Appeal brief filed 17 February 2009 do not appear to persuasively require a withdrawal of the Examiner's grounds of rejection. As specified in the remarks and rebuttals given above, Appellant's arguments apparently fail to appreciate the clear and unmistakable suggestions provided in the prior art of record, and relied upon by the Examiner for motivation to combine such well-known elements of the prior art. As such, it is respectfully submitted that an explanation based on logic and sound scientific reasoning of one ordinarily skilled in the art at the time of the invention that support a holding of obviousness has been adequately provided by the motivations and reasons indicated by the Examiner in the present Examiner's Answer, *Ex parte Levengood*, 28 USPQ2d 1300 (Bd. Pat. App. & Inter., 4/22/93).

For the above reasons, it is believed that the rejections should be sustained.

Respectfully submitted,

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/N. A. P./  
May 11, 2009

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